E. Calculation of Group Weights and Conversion Factor

1. Group Weights (Includes Table, 1, Packaged Services by Revenue Center)

Section 1833(t)(2)(C) of the Act requires the Secretary to establish relative payment weights for covered hospital outpatient services. That section requires that the weights be developed using data on claims from 1996 and data from the most recent available hospital cost reports. Before enactment of the BBRA 1999, we were required to base the relative payment weights on median hospital costs. Section 201(f) of the BBRA 1999 amended section 1833(t)(2)(ii) of the Act to authorize the Secretary to base the relative payment weights on either the median or mean hospital costs. In constructing the database for the outpatient PPS proposed rule group weights and conversion factor, we used a universe of approximately 98 million calendar year 1996 final action claims for hospital outpatient department services received through June 1997 to match to the most recent hospital cost reports available. We have decided to continue to base the relative payments weights in this final rule on median (as opposed to mean) costs because, among other things, reconstructing our database to evaluate the impact of using mean costs after the BBRA 1999 was enacted would have delayed implementation of the hospital outpatient PPS.

To derive weights based on median hospital costs for services in the hospital outpatient APC groups, we converted billed charges to costs and aggregated them to the procedure or visit level. To accomplish this, we first identified the cost-to-charge ratio that was specific to each hospital's cost centers ("cost center specific cost-to-charge ratios" or CCRs). We then developed a crosswalk to match the hospital's CCRs to revenue centers used on the hospital's 1996 outpatient bills. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education.

To determine the hospital CCRs, the most recent available cost report from each hospital was identified. For the proposed rule, we used cost reports from cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995 (referred to as PPS-12) or earlier. For this final rule, more recent cost reports were available for hospitals. We used cost reports from cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997 (PPS-14) for approximately 94 percent of the hospitals in our database.

If the most recent available cost report for a hospital was one that had been submitted but not settled, we calculated a factor to adjust for the differences that generally exist between settled and "as submitted" cost reports. The adjustment factor was determined by dividing the outpatient department cost-to-charge ratio from the hospital's most recent settled cost report by the outpatient department cost-to-charge ratio from the hospital's "as submitted" cost report for the same period. The resulting ratio was used to adjust each of the CCRs in the hospital's most recent "as submitted" cost report. We repeated this process for every hospital for which the most recent available cost report was a cost report that had not been settled.

The Office of Inspector General (OIG) for DHHS is concerned that the cost reports we are using may reflect some unallowable costs. Therefore, the OIG, in conjunction with HCFA, is proposing to examine the extent to which the cost reports used reflect costs that were inappropriately allowed. If this examination reveals excessive inappropriate costs, we will address this issue in a future

proposed rule, or perhaps seek legislation to adjust future payment rates downward.

We next eliminated from the hospital CCR database 258 hospitals that we have identified as having reported charges on their cost reports that were not actual charges (for example, they make uniform charges for all services). These excluded hospitals were Kaiser, New York Health and Hospital Corporation, and all-inclusive rate hospitals. After removing these hospitals, we calculated the geometric mean of the total operating CCRs of hospitals remaining in our CCR database. We identified 58 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations. These hospitals were also removed from our CCR database.

After assembling and editing our new CCR database, we matched revenue centers from approximately 80 million claims to CCRs of approximately 5,700 hospitals. We excluded from the crosswalk approximately 15 million claims in which the bill type denoted services that would not be covered under the PPS (for example, bill type 72X for dialysis services for patients with ESRD). We also excluded almost 3 million claims from the hospitals that we had removed or trimmed

from the hospital CCR database. The table below shows the five cost reporting periods used and the percentage of the cost reports within each PPS period for which we were able to match 1996 claims.

Reporting Period	Percentage of Cost Reports Matched
PPS-15 (cost reporting period beginning on or after 10/1/97 and before 10/1/98)	0.1
PPS-14 (cost reporting period beginning on or after 10/1/96 and before 10/1/97)	94.2
PPS-13 (cost reporting period beginning on or after 10/1/95 and before 10/1/96)	3.7
PPS-12 (cost reporting period beginning on or after 10/1/94 and before 10/1/95)	1.7
PPS-11 (cost reporting period beginning on or after 10/1/93 and before 10/1/94)	0.3
Total	100.0

Next, we took the estimated 80 million claims that we had matched with a cost report and separated them into two distinct groups: single-procedure claims and multiple-procedure claims. Single-procedure claims were those that included only one HCPCS code (other than laboratory and

incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims included more than one HCPCS code that could be mapped to an APC. There were approximately 45.4 million single-procedure claims and 34.6 million multiple-procedure claims.

To calculate median costs for services within an APC, we used only the single-procedure bills. (Of the roughly 45.4 million single-procedure claims, about 24 million were excluded from the conversion process largely because the only HCPCS codes reported on the claims were for laboratory procedures or other outpatient services not paid under the outpatient PPS.) This approach was taken because the information on claims does not enable us to specifically allocate charges or costs for packaged items and services such as anesthesia, recovery room, drugs, or supplies to a particular procedure when more than one significant procedure or medical visit was billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit. Although we used only single-procedure/visit bills to determine APC relative payment weights, we used multiple-procedure bills

in the conversion factor and service mix calculations, regressions, and impact analyses.

For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. If the appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or to the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under this PPS (for example, laboratory, ambulance, and therapy services).

To calculate the per-procedure or per-visit costs, we used the charges shown in the revenue centers that contained items integral to performing the procedure or visit. These included those items that we previously discussed as being subject to our proposed packaging provision. For instance, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and

organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, and observation. A complete listing of the revenue centers that we used is shown below in Table 1, Packaged Services by Revenue Center.

TABLE 1

PACKAGED SERVICES BY REVENUE CENTER

ASC AND OTHER SURGERY

250	PHARMACY
251	GENERIC
252	NONGENERIC
257	NONPRESCRIPTION DRUGS
258	IV SOLUTIONS
259	OTHER PHARMACY
260	IV THERAPY, GENERAL CLASS
262	IV THERAPY/PHARMACY SERVICES
263	IV THERAPY/DRUG/ SUPPLY/DELIVERY
264	IV THERAPY/SUPPLIES
269	OTHER IV THERAPY
270	M&S SUPPLIES
271	NONSTERILE SUPPLIES
272	STERILE SUPPLIES
276	INTRAOCULAR LENS
279	OTHER M&S SUPPLIES
370	ANESTHESIA
379	OTHER ANESTHESIA
390	BLOOD STORAGE AND PROCESSING
399	OTHER BLOOD STORAGE AND PROCESSING
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631	SINGLE SOURCE DRUG
632	MULTIPLE SOURCE DRUG
633	RESTRICTIVE PRESCRIPTION
700	CAST ROOM
709	OTHER CAST ROOM
710	RECOVERY ROOM
719	OTHER RECOVERY ROOM
720	LABOR ROOM
721	LABOR
723	CIRCUMCISION
762	OBSERVATION ROOM
810	ORGAN ACQUISITION
819	OTHER ORGAN ACQUISITION
890	OTHER DONOR BANK
891	BONE
892	ORGAN
893	SKIN
899	OTHER DONOR BANK

MEDICAL VISIT

250	PHARMACY
251	GENERIC
252	NONGENERIC
257	NONPRESCRIPTION DRUGS
258	IV SOLUTIONS
259	OTHER PHARMACY
270	M&S SUPPLIES
271	NONSTERILE SUPPLIES
272	STERILE SUPPLIES
279	OTHER M&S SUPPLIES
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631	SINGLE SOURCE DRUG
632	MULTIPLE SOURCE DRUG
633	RESTRICTIVE PRESCRIPTION
700	CAST ROOM
709	OTHER CAST ROOM
762	OBSERVATION ROOM

OTHER DIAGNOSTIC (BLENDED SERVICES)

254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC
622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC
710	RECOVERY ROOM
719	OTHER RECOVERY ROOM
762	OBSERVATION ROOM

RADIOLOGY SUBJECT TO THE FEE SCHEDULE AND OTHER RADIOLOGY

255	PHARMACY INCIDENT TO RADIOLOGY	710	RECOVERY ROOM
371	ANESTHESIA INCIDENT TO RADIOLOGY	719	OTHER RECOVERY ROOM
621	SUPPLIES INCIDENT TO RADIOLOGY	762	OBSERVATION ROOM

ALL OTHER APC GROUPS

250	PHARMACY	270	M&S SUPPLIES
251	GENERIC	271	NONSTERILE SUPPLIES
252	NONGENERIC	272	STERILE SUPPLIES
257	NONPRESCRIPTION DRUGS	279	OTHER M&S SUPPLIES
258	IV SOLUTIONS	630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
259	OTHER PHARMACY		
260	IV THERAPY, GENERAL CLASS		
262	IV THERAPY PHARMACY SERVICES	631	SINGLE SOURCE DRUG
263	IV THERAPY DRUG/SUPPLY/DELIVERY	632	MULTIPLE SOURCE DRUG
		633	RESTRICTIVE PRESCRIPTION
264	IV THERAPY SUPPLIES	762	OBSERVATION ROOM
269	OTHER IV THERAPY		

We then applied to these cost estimates an adjustment to calibrate the costs to calendar year 1996 for those services in hospitals whose CCRs were calculated using FY 1997 or later cost reports. On average, hospital charges were rising faster than costs in FY 1997. We therefore made this adjustment for the calculation of the weights, as well as for the hospital costs used in the conversion factor and impact model, to ensure that we did not underestimate costs and payments. We based this hospital specific CCR adjustment on the observed change in each hospital's overall CCR (total operating + total capital) from the proposed rule

cost report database to the new final rule database. If applicable, we then calculated a monthly rate of change and applied it based on the number of months past 1996 encompassed in a hospital's cost reporting period; if a hospital's period coincided completely within calendar year 1996, no adjustment was made.

After calibrating the costs to calendar year 1996, we standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the FY 2000 hospital inpatient prospective payment system wage index published in the **Federal Register** on July 30, 1999 (64 FR 41585). As in the proposed rule and correction notice, we used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. A more detailed discussion of wage index adjustments is found below in section III.G of this document.

The standardized labor-related cost and the nonlabor-related cost component were summed for each billed item to derive the total standardized cost for each procedure or medical visit. Extremely unusual costs that appeared to be errors in the data were trimmed from standardized procedure

and visit costs. This trimming methodology is analogous to that used in calculating the DRG weights for the inpatient PPS: eliminate any bills with costs outside of 3 standard deviations from the geometric mean. We used the geometric mean and the associated standard deviation because the distribution of costs more closely resembles a lognormal distribution than a normal distribution: there are no negative costs, and the average cost is greater than the median cost. Use of the geometric mean minimizes the impact of the most unusual bills in the determination of the mean. The geometric mean is calculated by taking the mean of the natural logarithm cost. Because the distribution of the natural logarithms of a set of numbers is more compact than the distribution of the numbers themselves, bills with extreme costs do not appear as extreme as they would if non-logged costs were examined. This ensures that only the most aberrant data will be removed from the calculation.

After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC and calculated the median cost for each APC weighted by procedure volume. Using the median APC costs, we calculated the relative payment weights for each APC. We scaled all

the relative payment weights to APC 601, a mid-level clinic visit, because it is one of the most frequently performed services. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. By assigning APC 601 a relative payment weight of 1.0, hospitals can easily compare the relative relationship of one APC to another. Next, we divided the median cost for each APC by the median cost for a mid-level clinic visit, APC 601, to derive the relative payment weight for each APC. The median cost for APC 601 is $47.00. In the proposed rule, we also used a mid-level clinic visit, APC 91336, which had a median cost of $54.00, as the scaler of APC weights. On average, due to the reduced value of the scaler used for this notice, the final weights will be higher than those published in the proposed rule.

Comment: Some commenters believe that the ratesetting methodology does not reflect complex cases because we eliminate statistical "outlier" claims from the calculation of the median costs and the weights.

Response: As noted above, we trimmed claims with estimated costs that were outside of three standard deviations from the geometric mean. Because we removed

claims above or below the mean, we corrected for data errors that would have skewed the estimates of median costs and group weights upward or downward. We believe this trim is a valid method of removing extremely unusual costs that are most likely associated with data submission errors and do not represent actual costs. In addition, it is consistent with the method we use to set inpatient hospital diagnosis-related group (DRG) weights.

Comment: Numerous commenters disagreed with our use of single-procedure claims only in the calculation of the relative payment weights. One commenter was concerned that we could be masking differences in resource use attributable to patient characteristics by using only single-procedure claims to calculate relative weights.

Response: We used single-procedure claims to calculate the relative weight for each APC because we could not accurately allocate costs to a particular procedure when the costs were part of a bill for multiple procedures. Bills with a single major procedure provided are, in most cases, the best estimate of relative procedure costs. It is important to note that for all other calculations, including

calculation of the conversion factor, we used both single-procedure and multiple-procedure bills.

We do not believe that using single-procedure bills biases the relative cost of any particular procedure. Although patients with more complex healthcare needs might have several procedures performed, hospital charges for an individual procedure would not be greater. Our most significant concern was that distribution of single bill procedures within an APC would not reflect the correct distribution of those procedure on all bills. However, careful statistical analyses demonstrated that the distribution of procedures within an APC group did not differ when single bill procedure frequencies were compared with all bills. It is also important to note that when items or services were to be packaged with a major procedure, we added their costs to that procedure prior to making the single bill determination. Therefore, the costs of contrast media, for example, are included in the relative weights. In some cases, we agreed with the commenters that this approach needed to be modified. For example, for chemotherapy, we are not grouping drugs, but rather paying for each one separately. Moreover, as a result of the

transitional pass-through provisions of the BBRA 1999, radiopharmaceuticals will be paid separately from the nuclear medicine APCs.

Comment: Several commenters expressed concern that the 1996 claims data are insufficient or inadequate to develop the PPS model. For example, some commenters asserted that the 1996 data are not recent enough to reflect the current mix of outpatient services. Some commenters also argued that undercoding in the data would lead to underestimates of median costs. Other commenters recommended that we address alleged inadequacies in the data by gathering cost data on new procedures and by basing payment on these data until we can determine whether to place a new procedure in an existing APC or create a new APC.

Response: While we acknowledge limitations of setting payment rates with historical claims data, section 1833(t)(2)(C) of the Act requires us to use 1996 claims in developing the PPS. We discuss how we will price new procedures that are not reflected in our database in section III.C.8 of this preamble.

Comment: Commenters were concerned about the cost-to-charge ratios used to estimate median APC costs and pre-BBA

payments. For example, one medical organization recommended that we account for the capital-intensive nature of radiology services by adjusting the cost-to-charge ratios applicable to these services for the step-down methodology that allocates capital expenses by square footage. The belief is that these allocation methods underestimate radiological equipment costs and certain cost-to-charge ratios, leading to underestimates of the median costs for relevant APC groups.

Response: Although capital-related costs may be allocated to routine and ancillary service cost centers using the step-down methodology based on square footage, as an alternative, the "dollar value" method may be used by hospitals. This method is made available to hospitals in Worksheet B-1 of the hospital cost report (HCFA 2552-96). The dollar value method more accurately distributes the capital costs associated with equipment to the revenue-producing cost center to which the equipment is assigned. We are not able to adjust the cost-to-charge ratios of those hospitals that allocate equipment based on square footage because we have no way of knowing which specific equipment

costs should be allocated to revenue-producing cost centers in each hospital.

2. Conversion Factor

Section 1833(t)(3)(C)(i) of the Act requires that we establish a conversion factor for 1999 to determine the Medicare payment amounts for each covered group of services. For the proposed rule as corrected, we derived the conversion factor from a base amount of payments described in section 1833(t)(3)(A) of the Act, as enacted in the BBA 1997. Such base amount was calculated for the services included in the outpatient PPS as an estimate of the sum of (1) total payments that would be payable from the Trust Fund under the current (non-PPS) payment system in 1999, plus (2) the beneficiary coinsurance that would have been paid under the new (PPS) system in 1999. For the final rule, however, we derived the conversion factor from a base amount that includes beneficiary coinsurance that would have been made under the current (non-PPS) system rather than the proposed (PPS) system. Section 201(l) of the BBRA 1999 states: "With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section

4523(a) of the BBA, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section."

Section 1833(t)(2)(C) of the Act requires us to project utilization for hospital outpatient services. We were unable to make precise projections of increases in the volume and intensity of services because we were not able to quantify some of the factors that affect utilization. For instance, we would anticipate that Medicare beneficiaries who choose to migrate to managed care plans may be healthier than those who choose to stay in fee-for-service plans. Thus, we could assume a decrease in the volume of services coupled with an increase in the intensity of services furnished for Medicare beneficiaries in the fee-for-service program. Another factor that we believe will affect future utilization is the incentive to code billed services more accurately. Currently, hospitals are paid for the majority of the outpatient services they furnish on a cost basis, and inaccurate or improper coding does not necessarily affect

the amount of payment. In contrast, under the PPS, hospitals are required to use HCPCS codes in order to receive payment. We expect that the frequency of some services may increase as a result of the coding requirements. We believe each of these assumptions will affect the reporting of volume and intensity of services, although we are not able to quantify them individually to project 1999 utilization. Therefore, we used what we believe to be a more reliable and valid approach to computing the conversion factor under the methodology described below.

Comment: A large national trade association commented that the exclusion of claims for unclassified services (for example, those claims for which we cannot identify the service to be paid) from the PPS model could bias the conversion factor downward if the excluded claims have a disproportionate number of services with high payment to cost ratios, such as clinic and emergency room visits.

Response: In order to set the conversion factor as accurately as possible, we used only claims for which the costs and volume of services could be identified on the bill. As noted by the commenter, this decision resulted in

the exclusion of claims with unclassifiable services. Upon examination of these claims, we have determined that services with high payment to cost ratios (those that would gain under the PPS system) were not disproportionately represented. Therefore, we believe the exclusion of unclassifiable services does not bias the conversion factor.

Setting the Rates

In order to convert the relative weights determined for each APC (see section III.E.1) into payment rates, we calculated a conversion factor that would result in total estimated payments to hospitals under the PPS in 1999 equal to the total estimated payments that would have been payable from the Trust Fund in 1999 if PPS had not been enacted plus estimated beneficiary coinsurance for the same services during the same period. The prospective payment rate for each APC is calculated by multiplying the APC's relative weight by the conversion factor. For the calculation of the conversion factor, we have excluded all data from the 58 Maryland providers that qualify under section 1814(b)(3) of the Act for payment under the State's payment system. We computed the conversion factor by first adding together the aggregate Medicare hospital outpatient payments made under

the cost-based payment system (referred to in this section as pre-PPS payments) for calendar year 1996, plus the estimated beneficiary coinsurance amounts made under pre-PPS law for the same services. We then divided that amount by a wage-adjusted sum of the relative weights for all APCs under the hospital outpatient PPS. The methodology we used to determine current law Medicare hospital outpatient payments and beneficiary coinsurance is discussed below in section III.E.2.a. A discussion of the sum of the relative weights follows in section III.E.2.b.

a. Calculating Aggregate Calendar Year 1996 Medicare and Beneficiary Payments for Hospital Outpatient Services (Pre-PPS)

To calculate Medicare hospital outpatient payment amounts before implementation of the PPS, we first identified calendar year 1996 single and multiple procedure bills for all the services that we will recognize under the outpatient PPS. As we identified services that will be paid under the outpatient PPS, we eliminated invalid or noncovered HCPCS codes.

Hospital payments include both operating and capital costs for the HCPCS coded services for which payment is to

be made under the outpatient PPS. We summed these two types of costs by HCPCS code at the provider level. Consolidating the data in this manner allowed us to simulate provider payment on an aggregate basis. Then (as required by section 1861(v)(1)(S)(ii) of the Act as amended by section 201(k) of the BBRA 1999), we applied the capital cost reductions of 10 percent and operating cost reductions of 5.8 percent.

We determined for each HCPCS code the applicable payment methodology under the current system. Payment before implementation of PPS for procedures in the baseline was calculated using one of the following equations, as appropriate:

• For radiology procedures paid for under the radiology fee schedule, we determined payment in the aggregate for each provider as the lower of the cost, charge, or blended amount. We use the following equation to determine the radiology blended amount:

(0.42 x lower of cost or charge minus beneficiary coinsurance) + (0.58 x ((0.62 x global physician fee schedule amount) - beneficiary coinsurance))

• For surgical procedures for which Medicare pays an ASC facility fee, we determined payment in the aggregate for

each provider as the lower of the cost, charge, or blended amount. We used the following equation to determine the ASC blended amount:

(0.42 x lower of cost or charge minus beneficiary coinsurance) + (0.58 x (ASC payment rate - beneficiary coinsurance))

• For diagnostic procedures paid for under the diagnostic fee schedule, we determined payment in the aggregate for each provider as the lower of the cost, charge, or blended amount. We used the following equation to determine the blended amount for diagnostic procedures:

(0.50 x lower of cost or charge minus beneficiary coinsurance) + (0.50 x ((0.42 x global physician fee schedule amount) - beneficiary coinsurance))

For all other covered services not subject to one of the blended payment method categories, we determined payment as the lower of costs or charges less beneficiary coinsurance. Because the formula-driven overpayment (FDO) was corrected beginning October 1, 1997, the blended equations eliminate FDO.

We then determined the Medicare payment amount for each provider by summing the aggregate amounts computed for each of the four types of payment methodologies discussed above. In addition, we determined the amount of the beneficiary

coinsurance for each provider using the beneficiary coinsurance amounts that would have been paid before implementation of PPS. The total amount (Medicare and beneficiary payments) reflects the amount hospitals would be paid under the PPS and is the numerator in the equation for calculating the unadjusted conversion factor.

b. Sum of the Relative Weights

Next we summed the discounted relative weights for services that are within the scope of the outpatient PPS. (See discussion of discounting for surgical procedures in section III.C.7.) Specifically, we multiplied (using single and multiple procedure claims in a hospital) the discounted volume of procedures or visits in each APC group by the relative weights for each APC group; we wage-adjusted 60 percent of this total by each hospital's wage index, and we then summed the wage-adjusted and nonadjusted weights across all hospitals. (The wage indices used are included in Addenda H, I, and J.) The resulting sum equals the denominator in the calculation of the conversion factor. We calculated the conversion factor by dividing the sum of the discounted relative weights into the total payment explained in section III.E.2.a, above, including both Medicare payment

and beneficiary coinsurance. We then adjusted the conversion factor so that the outlier and pass-through payments are implemented in a budget neutral manner, as described in sections III.H.1 and III.D. The adjusted calendar year 1996 conversion factor is $43.023. To inflate the 1996 conversion factor to 1999, our Office of the Actuary estimated an update factor of 1.106. Therefore, the adjusted 1999 conversion factor is $47.583.

For calendar year 2000, we updated the conversion factor as specified in section 1833(t)(3)(C)(iii) of the Act. The update is the market basket percentage increase applied to hospital discharges occurring during the fiscal year ending in calendar year 2000 minus 1 percentage point. For 2000, the updated conversion factor is $48.487.

Comment: A number of commenters suggested that we remove the behavioral offset that we proposed to apply to the conversion factor. As proposed, the intent of the offset was to adjust for hospital coding changes that take place in response to reductions in beneficiary coinsurance.

Response: We have decided not to include a behavioral offset to the conversion factor in this final rule. Hospital coding changes are expected to occur under the

outpatient PPS; however, we believe changes that occur during the first PPS years will result from hospitals billing more accurately under the new system. A behavioral offset implemented in the initial PPS years may distort the incentives to bill accurately. We may reconsider implementation of a behavioral offset in future years as we gather data and gain experience under the new system.

Comment: A large national trade association expressed concern that application of the 5.8 percent and 10.0 percent reduction to costs for all hospital outpatient services included in the PPS model underestimates the conversion factor. They recommended that we exclude the Part B services provided to inpatients who exhaust their Part A benefits from the reductions.

Response: Our analysis shows that fewer than 5,000 of the more than 80 million claims used to set the conversion factor were associated with these types of services. Total costs associated with these claims were less than $1.4 million, which is too small to have a measurable effect on the conversion factor.

Comment: Many commenters strongly argued that we misinterpreted the provisions of section 1833(t)(3) of the

Act in calculating beneficiary coinsurance for purposes of setting the base amount of the conversion factor. The commenters noted that this methodology contributed significantly to the estimated 5.7 percent reduction in Medicare outpatient payments to hospitals reflected in the proposed rule. Most commenters further argued that the Congress did not intend for this loss to occur and that we had the authority to interpret the methodology described in the statute so that no net change in payments would result from the conversion factor.

Response: Section 1833(t)(3)(A) of the Act, as added by the BBA 1997, states that, for purposes of calculating the base amount used to determine the conversion factor, the Secretary shall calculate "the total amount of copayments estimated to be paid under this subsection...." (Emphasis added.) For the proposed rule, we estimated the coinsurance that would be paid under PPS. In section 201(l) of the BBRA 1999, the Congress addressed the calculation of the base amount, stating, "With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of the BBA, Congress finds that such amount should

be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and the Secretary of Health and Human Services has the authority to determine such amount without regard to such section." Therefore, for this final rule, we estimated the coinsurance that would have been paid if PPS had not been enacted.